

# Casebook July 2025: Investigations and complaint-handling case studies

A special report under section 31 of the *Ombudsman Act 1974*



Pursuing fairness for  
the people of NSW.

 **Ombudsman**  
New South Wales

The Hon. Ben Franklin, MLC  
President  
Legislative Council  
Parliament House  
SYDNEY NSW 2000

The Hon. Greg Piper, MP  
Speaker  
Legislative Assembly  
Parliament House  
SYDNEY NSW 2000

Dear Mr President and Mr Speaker

Pursuant to s 31 of the *Ombudsman Act 1974*, I am providing you with a report titled *Casebook July 2025: Investigations and complaint-handling case studies*. The report includes a selection of case studies relating to complaint matters finalised in the period from 1 January 2025 to 30 June 2025, as well as a summary of an investigation completed in that period.

I draw your attention to section 31AA of the Act in relation to the tabling of this report and request that you make the report public forthwith.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Paul Miller', written in a cursive style.

Paul Miller  
**NSW Ombudsman**  
31 July 2025



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# Introduction

## The NSW Ombudsman

The NSW Ombudsman is an independent integrity agency that pursues fairness for the people of NSW. We strive to ensure that those entrusted with public power and resources fulfil their responsibilities and treat everyone fairly.

One of our central functions is to receive and respond to complaints from the public about NSW public authorities, local councils and community service providers funded by the NSW Government.

Anyone can contact us to complain if they believe they have been treated unfairly by any of the bodies we can handle complaints about, or to report concerns about possible maladministration.

Our services are free to the public. We are fully independent, and we act impartially in the public interest. People who complain to us are protected by law if anyone tries to retaliate against them. Additional protections apply for public official whistleblowers who report serious wrongdoing to us under the *Public Interest Disclosures Act 2022*.

Under the *Ombudsman Act 1974* (**Ombudsman Act**) the Ombudsman may conduct an investigation into the conduct of a public authority<sup>1</sup> or a community service provider<sup>2</sup> if it appears to the Ombudsman that the conduct, or any part of it, may be:

- contrary to law
- unreasonable, unjust, oppressive or improperly discriminatory
- in accordance with any law or established practice but the law or practice is, or may be, unreasonable, unjust, oppressive or improperly discriminatory
- based wholly or partly on improper motives, irrelevant grounds or irrelevant considerations
- based wholly or partly on a mistake of law or fact
- conduct for which reasons should be given but are not given, or
- otherwise wrong.<sup>3</sup>

In the case of complaints about community service providers, in addition to the above, the Ombudsman may also investigate a complaint if it appears to the Ombudsman that it raises a significant issue of public safety or public interest, or a significant question as to the appropriate care or treatment of a person by a service provider.<sup>4</sup>

Investigations can be commenced whether or not anyone has complained to the Ombudsman about the conduct in question.

Most complaints we receive do not result in a formal investigation. This is because we generally aim to resolve complaints at the earliest stage possible. If a satisfactory outcome can be achieved through inquiries or conciliatory engagement with the agency and the complainant, we will take that action.

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<sup>1</sup> Under s 246 of the *Crimes (Administration of Sentences) Act 1999*, the Ombudsman Act also applies to the management company, governors and staff of privately-run correctional centres as if they were public authorities.

<sup>2</sup> Under s 24 of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (CS CRAMA), the Ombudsman Act applies to complaints about community service providers as it does to complaints about public authorities.

<sup>3</sup> Section 26 Ombudsman Act.

<sup>4</sup> Section 27 CS CRAMA.

Our office has a range of other statutory functions in addition to complaint handling and investigation, including monitoring and reviewing government programs and services. We also provide guidance and training for agencies in complaints management. See our [website](#) and [annual reports](#) for more information.

## About this report

This report contains a range of case studies to promote shared learning about how to improve decision making and administrative processes for those we oversight. Additionally, the case studies inform Parliament and the public about the work of the Ombudsman by demonstrating ways in which we have held agencies to account and how we have reached positive outcomes for the people of NSW.

The report comprises 2 parts:

- Part 1 includes a summary of a formal investigation finalised between 1 January 2025 and 30 June 2025.
- Part 2 includes a selection of case studies relating to complaint matters finalised during that period.

A summary of the *6 principles for effective complaint management* is appended to the report. These principles are a guide for all public sector agencies on the essential requirements for effective complaint management.

## A note about investigation reports

If, following investigation, wrong conduct is found to have occurred, the Ombudsman must produce an investigation report. That report must be provided to the relevant public authority and to the relevant minister. The Ombudsman may also report the outcomes of the investigation to the complainant.

The investigation report is not otherwise made public by the Ombudsman, unless the Ombudsman decides to table a special report to Parliament.

Any request for a copy of an investigation report would need to be made to the relevant public authority or the relevant minister, who would need to consider any public interest considerations for and against disclosure. The investigation report is 'excluded information' under the *Government Information (Public Access) Act 2009 (GIPA Act)* and an application cannot be made to the Ombudsman for it under the GIPA Act.

The Ombudsman may, however, make a special report to Parliament at any time on any matter arising in connection with the discharge of the Ombudsman's functions. Following the completion of an investigation, the Ombudsman may consider tabling a separate, special report concerning the investigation. That is typically done where the investigation (or a series of investigations) raises particularly significant issues of broader public interest.

These reports include a summary of any investigation concluded in the relevant 6-month period, regardless of whether a special report has also been tabled in respect of the investigation.

## Confidentiality

We do not use real names of complainants and otherwise seek as far as possible to omit other identifying information in this report. Agencies that are identified have been given an opportunity to comment on the factual accuracy of any case studies concerning their actions.

# Part 1: Investigations summaries



# Part 1: Investigations summaries

In the period 1 January to 30 June 2025, we started 5 new investigations and continued work on 11 open investigations. We finalised 1 investigation, which is summarised below.

## Investigation into the management of an inmate during and after he had a seizure

### The case of GEO Group Australia Pty Ltd

<b>Public authority:</b>	GEO Group Australia Pty Ltd (GEO)
<b>Responsible minister:</b>	Minister for Corrections
<b>Investigation report issued:</b>	30 June 2025
<b>Findings:</b>	Some conduct was contrary to law, and some was unreasonable and unjust
<b>Recommendations:</b>	Apology and changes to inmate's record; consideration of the need for staff training; referral to the use of force committee

We investigated the conduct of GEO (which, at the relevant time, operated Junee Correctional Centre (**Junee**) relating to its use of force and restraining of an inmate, the way he was questioned after the incident, and the conduct of any reviews into the incident. We also investigated GEO's conduct in connection with the subsequent charging of the inmate with the correctional centre offence of assault, and the inquiry process, determination of the charge and the imposition of penalties.

## Background

We received a complaint from an inmate who said he was unfairly charged with and recorded as being guilty of assault on officers. He told us he had been charged with the offence because of his actions during an incident where he had a seizure and where officers had used force to restrain him. He felt this was unfair as he cannot control his seizures.

The information we reviewed, including video footage, showed that officers were called by inmates to respond to another inmate who appeared to be experiencing a seizure. Officers called health staff who arrived approximately 3 minutes later. Before health staff arrived, the inmate stood up and made clumsy swinging and kicking motions with his arms and legs in the general direction of officers. His feet appeared to come into superficial contact with officers. Force was used to bring him to the ground and restrain him, and then to lift him to his feet. He was placed on a stretcher, handcuffed and taken to the clinic.

While at the clinic, and prior to being medically cleared, the inmate was questioned about the incident.

The officer who questioned the inmate had been involved in the incident, including when he was being restrained. This is contrary to policy that post-incident processes be conducted at arms-length from the incident itself by impartial officers.

The inmate was interviewed and asked to complete and sign the questionnaire while he was being subjected to medical tests, and at a time when the officer questioning him acknowledged his cognitive functioning was likely impaired.

Officers completed reports into the use of force, and a review of the use of force was conducted. However, the reports were not accurate, and the review was not completed to a satisfactory standard.

The inmate was subsequently charged with assault, and an inquiry process was undertaken. During the hearing, the inmate was recorded as pleading guilty, even though he was also recorded as stating, 'can't remember sorry boss'. He was penalised by way of a 28-day reprimand and caution. Records stated, 'reprimand and caution due to medical episode.'

## What did we find?

The conduct of GEO was contrary to law, as:

- The offence of physical assault requires proof that a person (in striking or touching another person) has acted voluntarily. The inmate here was found guilty of and penalised for this offence when the available evidence was incapable of proving the charge, particularly to the standard of beyond reasonable doubt.
- The inquiry process for the offence was not conducted in accordance with relevant legislative provisions.

The conduct of GEO was unreasonable and unjust. In particular:

- The inmate should not have been questioned by an officer involved in the incident, while being medically assessed and when he had not yet fully recovered or been medically cleared.
- The reports and reviews conducted following the incident were not done to a satisfactory standard, including in so far as the incident was not referred to the Use of Force Review Committee as possibly being an unreasonable, unwarranted, unjustified or excessive use of force.

## What did we recommend?

We recommended that:

- Corrective Services NSW update records relating to the finding of guilt against the inmate for the correctional centre charge of assault, to reflect that the finding is unsound and should be disregarded in future decisions.
- GEO write to the inmate and apologise for charging him with assault, and inform him that the guilty finding of the charge has been recorded as unsound and will be disregarded in future decisions.
- Corrective Services NSW (which now manages Junee) consider whether remedial action (for example referring the matter to the Use of Force Review Committee; further guidance for officers working at Junee) is warranted, and take action accordingly.

# Part 2:

## Complaint-handling case studies



# Part 2: Complaint-handling case studies

This part provides summaries of some complaints we finalised during the period 1 January to 30 June 2025.

We receive complaints over the phone, in person or in writing, including through our online complaint form. Any person can complain to us about:

- the conduct of a public authority, including any action or inaction, or alleged action or inaction relating to a matter of administration (unless it is excluded conduct) under the Ombudsman Act.
- the conduct of service providers with respect to the provision, failure to provide, withdrawal, variation or administration of a community service under the *Community Services (Complaints, Reviews and Monitoring) Act 1993 (CS CRAMA)*.

Between 1 January and 30 June 2025, we received 8,457 ‘actionable complaints’ – that is, complaints about a public authority or community service provider that we are authorised to deal with.

## How we handle complaints

We have a range of ways that we manage and resolve complaints outside of conducting a formal investigation. This part of the report demonstrates the kinds of outcomes the Ombudsman can achieve through the different means available to us.

Our aim is to resolve complaints as early and efficiently as possible. Many complaints are finalised by our staff providing information and advice to complainants – for example, guidance on how to navigate an agency’s complaint-handling process. With some larger agencies, complaints can be directly referred to them with the complainant’s consent, allowing the agency a chance to resolve the matter without the need for our office to intervene.

We can make preliminary inquiries under s 13AA of the Ombudsman Act for the purpose of deciding whether the conduct of an agency should be the subject of an investigation. Most complaints that result in preliminary inquiries are finalised without proceeding to an investigation. Inquiries can provide information that assists in resolving the complaint – sometimes the information suggests that no further action is warranted, and we are in a better position to explain to the complainant why this is the case.

In other cases, our inquiries prompt agencies to take corrective action to resolve the complaint (for example, by reviewing a decision, providing an apology, taking action where there has been unwarranted delay, or undertaking some other action), or to provide the complainant with (clearer) reasons or further information that addresses their concerns.

In the process of resolving a complaint we may make formal comments or suggestions to an agency under s 31AC of the Ombudsman Act. These comments are generally aimed at assisting an agency to improve its service delivery or its own complaint-handling practices.

We can and do also make comments to suggest an agency take steps to address a complainant’s particular concerns, such as issuing an apology or taking some other action to resolve the situation.

Alternatively, we can manage a complaint under s 12A of the Ombudsman Act, which enables us to refer a complaint to a public authority for it to conduct an investigation. In those cases, the public authority is required to report back to us on the outcome. Using similar powers under CS CRAMA, we can also refer

a community services complaint to the relevant department or a provider to resolve a complaint at a local level and report back to us on the outcome.

Finally, we can conciliate a matter either under s 13A of the Ombudsman Act or under s 74 of the *Public Interest Disclosures Act 2022* (NSW) (the **PID Act**). Conciliation is held on a voluntary basis and can be most helpful where there is an ongoing relationship between the complainant and the agency that needs to be repaired or restored.

The case studies below provide a range of examples of how we use these powers.

## Introduction to the case studies

When we finalise a complaint, there are almost always lessons to be learned. For a number of the matters highlighted in this report we have identified key learnings in administrative conduct that could apply to any public authority or service provider. They are provided here in support of broader sector improvement.

This report also provides greater transparency around the work we do and illustrates how our services make a difference for the people of NSW.

In this casebook, we have included several successfully conciliated matters, highlighting the use of that process as a complaint resolution mechanism. During the period 1 January to 30 June 2025, we commenced the conciliation of 12 complaints.

Our conciliations have been successful across a range of sectors and issues. For example, we conciliated a university's handling of an application for course credit. Conciliations can also be effective in addressing complex and sensitive matters. Below there are 2 case studies relating to young Aboriginal people requiring additional support with their housing and living circumstances. In both matters, the Department of Communities and Justice apologised and undertook to implement a range of supports.

The 6 principles for effective complaint management are included in the Appendix to this report – they are a guide for all public sector agencies on the essential requirements for effective complaint management.

One of the principles is **taking ownership**. The case study about Revenue NSW and exemption from transfer duty shows the importance of an agency remaining open to reconsidering decisions when appropriate such as when new information becomes available. Following our intervention, the complainant's duty payable was reduced from \$68,000 to \$50 (plus interest).

Another of the principles is **respect** because treating complainants as individuals who have dignity and deserve respect can restore trust and prevent unnecessary escalation of complaints. The case involving a tenant's experience with Homes NSW underscores the fundamental importance of understanding customer needs and using a flexible and tailored approach to support a respectful experience for those with complex trauma needs.

In a local government matter, our intervention led to hardship support for a person and saving their impounded dog from euthanasia. Council's flexibility and willingness to resolve the matter restored the relationship between council and the complainant.

# A social housing tenant's multiple housing issues

## Public authority: Homes NSW

### Complaint overview

A social housing tenant told us she was being harassed by her neighbours. She had successfully sought an apprehended violence order against one of her neighbours, and she was seeking additional support from Homes NSW to manage the situation and to address other complaints of inappropriate neighbour behaviour (for example, she claimed illegal parking had been occurring and that her neighbour in the unit above had been throwing objects off their balcony).

The tenant had also received notice of rent arrears, which she disputed. In addition, she had lodged several maintenance requests that had not been addressed. She is visually impaired, and the maintenance issues were urgent.

We conciliated the complaint.

### What was the outcome?

The tenant was able to reach an agreement with Homes NSW through conciliation. The agency undertook to action the repairs required without further delay (and did so the day after the conciliation meeting) and provided clear information to the tenant about how to request repairs and maintenance in future.

Homes NSW clarified the process for installing air conditioning (related to the tenant's health condition) so the process could begin without further delay. It also made an undertaking to investigate the disputed rent arrears, resulting in some rent being reimbursed.

Homes NSW also undertook to communicate with all tenants to address inappropriate behaviour, and to investigate specific complaints as per policy. It provided the tenant with an efficient and timely communication process to use if issues arose in future.

### What can we learn?

This case highlights the importance of treating complainants with respect. It also shows how important it is for agencies to manage issues in a timely manner. In this case our inquiries helped facilitate a resolution to the tenant's longstanding concerns, and ensured she was provided with correct information about who was responsible for maintenance.

# Supporting a customer from a culturally and linguistically diverse background through the priority housing application process

## Public authority: Homes NSW

### Complaint overview

A public housing applicant told us she was having difficulty finalising her application for public housing. She is a single parent with 2 small children, and she and her children all have medical conditions. She had applied for public housing and then gone overseas, and when she returned Homes NSW told her that her application had been closed. She did not understand why this had happened.

We conciliated the complaint at the offices of Homes NSW, with an interpreter present.

### What was the outcome?

The applicant and Homes NSW were able to reach an agreement. Homes NSW told the applicant it would assess her application for housing as a matter of priority – noting, however, that she was missing some of the required documentation.

The applicant had brought some of the required documentation to the conciliation. Homes NSW agreed to urgently write to her setting out which documents remained outstanding. It also undertook to assess her application for priority housing within a week of receiving the required information.

Homes NSW also explained in detail (with the assistance of the interpreter) relevant policies around the impact of overseas travel on her housing application.

### What can we learn?

This conciliation demonstrated the value in meeting with applicants from culturally and linguistically diverse backgrounds so that they can better understand the application process and what is required to make an application for public housing.

# Addressing poor customer service

## Public authority: Transport for NSW Maritime

### Complaint overview

A couple told us they had applied for and paid for a mooring for their boat. However, Transport for NSW (**TfNSW**) was unable to advise where the mooring was. The complainants had contacted TfNSW on multiple occasions. They told us communication from the agency had been sporadic and did not address the issue.

We conciliated the complaint.

### What was the outcome?

The complainants were able to reach an agreement with TfNSW through conciliation. TfNSW acknowledged the poor customer service they had provided, noting that customers should be contacted in a timely manner and taken to the mooring site by a boating safety officer. It said it would use the complainants' experience to upskill their boating safety officers to do this better in future.

TfNSW also explained that, prior to the conciliation, it had installed a new mooring at no cost to the complainants, created a new licence for them and credited their account for 12 months. It had also had discussions with boating safety officers about how customer service could be improved for mooring applicants.

It provided a specific contact for the complainants to use if any issues arise in future. It also developed a boating safety officer customer service course (which has been delivered on the Mid North Coast) to uplift customer service skills and capabilities.

### What can we learn?

This case shows that when things go wrong, an honest conversation between the affected customer and the government agency involved can help restore the customer's trust in the agency. It also shows that government agencies can gain useful information from hearing about the experiences of their customers, which can inform improvements like the delivery of targeted training to uplift customer service capability.

# Responding to delays

## Public authority: a local health district

### Complaint overview

A complainant was dissatisfied with a local health district's communication and management of a clinical incident involving a family member, including a delay of 6 months in finalising their investigation report. The complainant told us that the local health district had not met the timeframes set out in their *Serious Incident Management Policy*.

We made inquiries with the local health district.

### What was the outcome?

The local health district acknowledged that, according to the policy, the investigation should have been completed within 45 days. It explained that there were various factors that contributed to the delay, but it accepted that earlier resolution and communication of the findings with the complainant may have alleviated some of their distress and concern.

The local health district reflected on the matter and acted to streamline its monitoring processes for clinical reviews and investigations. It also integrated a centralised tracking database to ensure compliance.

As part of the incident investigation and complaint management process, the local health district committed to inviting the complainant to an open disclosure meeting to discuss the findings, address the delays in finalising the report and to allow it to apologise for the negative experience they'd had.

### What can we learn?

While many factors can impact an agency's compliance with timeframes, this case shows that by taking the opportunity to communicate with complainants in a timely manner, agencies can help them understand the process and potentially reduce their distress.

# Conciliating a credit assessment for completion of an MBA

## Public authority: a University

### Complaint overview

A student was nearing the completion of her Master of Business Administration (**MBA**) degree. She had been granted an 'exemption' for 5 compulsory units – this meant that, because of her prior learning in those same areas, she was able to choose different units instead of those 5 mandatory ones. However, she would still need to complete the overall number of units for the MBA program. The student asked the university to reassess its decision and provide her with 'credits' for those units instead. That would mean that the student would not have to do those 5 units (or any other 5 substitute units) and would be immediately eligible to graduate.

The university assessed her request and granted credit for 3 of the 5 units based on her prior experience. It said it was not able to apply credit for 2 of the units only because there was a cap of 24 credits that allowable for the degree, and the student had reached that cap. In response, the student noted that the MBA admission handbook stated that 36 credit points were permitted.

We conciliated the complaint.

### What was the outcome?

As a result of the conciliation, the MBA student was offered an option that was acceptable to her, and which enabled her to complete her remaining unit and attain her MBA (pending successful assessment) without further delay – allowing her to graduate in the first half of 2025 and at a significantly reduced cost than if she had been required to take further units.

Her objectives were met, and the complainant wrote to us to inform that she had passed her final assessment task, and to thank us for our help.

### What can we learn?

This case demonstrates the importance of consistency in policy across publications to ensure students can make course decisions in an informed manner. Additionally, conciliation can be an effective tool to understand complex decision-making processes and reach a satisfactory resolution without undue delay.

# Addressing poor customer service

## Public authority: Corrective Services NSW

### Complaint overview

In December 2024, a man in custody complained to us that he had recently been moved between correctional centres and an item of his personal property, a television, had been misplaced. He said he had raised this with Corrective Services NSW (CSNSW) and been advised that the television had been disposed of because it had been left unclaimed at the previous centre for 3 months, and was therefore considered abandoned.

### What was the outcome?

We made inquiries with CSNSW and received confirmation that the television had been disposed of. We were told that following our inquiries CSNSW had offered the complainant \$200 as compensation. However, the complainant had declined the payment as he believed it would not adequately compensate him for the television (which was quite new) nor would it enable him to purchase another.

Our review suggested that the television may have been disposed of in contravention of the relevant policy, which stated that the centre holding the television had a responsibility to transfer it to the man's current location in a timely manner. The television should only have been considered abandoned if it was left unclaimed for 3 months after the man had been released from custody.

We contacted CSNSW again so that we could better understand the issues raised and decisions made. As a result, CSNSW confirmed that the complainant had been given incorrect advice and told us that the correctional centre had agreed to pay \$337.50 as compensation, which would cover the cost of a new television.

### What can we learn?

This case demonstrates that even when an agency accepts responsibility for remedying a complaint, a follow up is sometimes warranted to ensure there is a fair outcome.

# Reversing debt recovery actions due to errors in recordkeeping

## Public authority: a local Council

### Complaint overview

A complainant contacted us about a lump sum of \$9,000 for rates and charges that was alleged to be owing on their property. They explained that despite making multiple complaints to Council, they had not received a response about the application of a pensioner concession and assistance with financial hardship. Council had already initiated debt recovery action and filed a statement of claim with the Local Court.

We contacted Council for clarification of its reasons for the alleged debt amount and apparent lack of response to the complainant's requests for assistance.

### What was the outcome?

Council acknowledged that records were not properly kept by its rates team. Its newly appointed rates coordinator also identified an error in Council's procedures relating to the registration of the complainant's land title.

Consequently, Council withdrew its statement of claim in the Local Court, waived the legal and interest charges against the complainant and closed the debt recovery file. It also applied a full pensioner concession, adjusted the rate account, offered a voluntary discount on waste services for future years, and gave the complainant information about its financial hardship policy in case they needed any further support.

Council committed to running refresher complaint-handling training for its staff. It also committed to a review of its policies and procedures to ensure that similar situations do not occur in the future.

### What can we learn?

This case highlights the importance of good complaint handling which, if it had occurred in this case, would have addressed the complainant's concerns without needing our involvement.

It is also a reminder of the need to keep proper records so ratepayers' circumstances can be managed accurately to avoid the situation escalating to debt recovery and court proceedings.

# Parking fine cancelled due to misleading parking app

## Public authority: a local Council

### Complaint overview

A complainant was issued a parking fine by a Council ranger even though the NSW Government 'Park'nPay' app had indicated that the parking space was free of charge. They complained to us as they thought the fine was unjust.

We made inquiries with Council and Revenue NSW.

### What was the outcome?

Revenue NSW put its enforcement action on hold while the matter was being reviewed. Council explained that it identified what appeared to be a programming issue with the Park'nPay app whereby it did not indicate that an e-ticket was still required for free parking, and there was no way for the complainant to obtain one.

Council requested that Revenue NSW rescind the complainant's fine, and committed to resolving the issue with the app.

### What can we learn?

This case shows the importance of ensuring that apps that are used to access an agency's services provide a good, error-free customer experience. This can potentially be addressed through better testing prior to adoption, and obtaining user feedback after adoption.

# Cancelling parking fines due to contradictory signage

## Public authority: a local Council

### Complaint overview

A complainant had parked on a local road with an unbroken yellow 'no stopping' line. However, the street where the complainant was parked was apparently also subject to a '6P' (i.e. six hour parking permitted) sign.

The complainant was issued a fine for illegal parking by a Council officer. They complained to us that Council's parking signage appeared to be contradictory, as it suggested parking in that zone was permissible when it wasn't.

We made inquiries with Revenue NSW and Council.

### What was the outcome?

Revenue NSW told us that because it was not aware of Council's error at the time, the fine appeared to be validly issued for a vehicle parked on the no stopping line, so it did not seek Council's view to withdraw the fine. Council explained that it had already internally identified the issue with signage and sought to rectify it. However, these works were not completed until more than 2 weeks after the initial marking, and in this time Council's parking rangers had issued infringements.

We suggested to Council under s 31AC of the Ombudsman Act that it review the infringements in light of the error. Council agreed to rescind the infringements issued and contacted Revenue NSW to inform it of the issue. Council also committed to provide further training and improve internal communication between teams to avoid this situation happening again.

### What can we learn?

This case highlights the importance of good internal communication within large agencies, including local councils. Council's operational teams had identified the parking signage issue and developed a plan to resolve it, but they did not communicate this to Council's enforcement officers.

It also highlights the responsibility of agencies to be proactive and collaborative when an issue is identified, to avoid further problems.

# A tailored approach for tenants with complex needs

## Public authority: Homes NSW

### Complaint overview

A complainant contacted us on behalf of her son, who has complex physical and psychological health issues. The complainant raised concerns about delays to modifications needed at her son's property to meet his health needs, and a lack of appropriate communication by Homes NSW.

The complainant herself also has significant health issues, and she required Homes NSW to accommodate her needs while the modifications were completed.

The complainant attempted to resolve the matter directly with the agency but told us she had had difficulty doing so, including receiving different information from different staff members.

We wrote to Homes NSW requesting information about the issues the complainant raised, and sought further details throughout the process.

### What was the outcome?

The responses Homes NSW provided showed there had been delays in approving and referring the requested modifications to the appropriate area of the department. We acknowledged that the case presented challenges due to the complex needs of the complainant and her son. However, it also presented opportunities for improved communication and management of expectations that may mitigate similar issues in the future.

After considering the information provided by Homes NSW, we used the provisions under s 31AC of the Ombudsman Act to make comments and suggestions to Homes NSW.

We suggested that Homes NSW adopt a tailored approach to minimise distress and set clear expectations when tenants or carers have identified complex needs, such as providing a trauma-informed approach which may involve a single point of contact. The suggestions were to consider having thorough discussions with tenants and carers about the modifications, including any limitations beyond the agency's control and also provide a schedule of the works to be performed.

Homes NSW accepted our suggestions and comments, including adopting a more tailored service delivery for tenants such as the complainant. The modifications were also completed for the complainant's son during this process.

### What can we learn?

This case highlights the importance of understanding clients' needs, and the benefits of taking a flexible and tailored approach to support clients with complex trauma needs and create a respectful experience for them. The suggestions that Homes NSW accepted can be implemented and applied to other tenants and their carers in similar situations, and where ongoing relationships exist.

# Seeking an exemption from transfer duty

## Public authority: Revenue NSW

### Complaint overview

A complainant told us she was attempting to transfer an apartment to herself from a company title to a strata Torrens title after originally inheriting shares in the company in 2008. There is a concession which results in nominal duty when changing a company title to a strata title, where the beneficial ownership does not change.

Revenue NSW sought a key document from 2008 from the complainant, but she did not have a copy of it. As she could not provide the document, it issued a notice to pay \$68,000 in transfer duty. The complainant had secondary documents that would have allowed her to obtain the concession that were not provided in the initial application.

We made inquiries with Revenue NSW.

### What was the outcome?

Following our inquiries, Revenue NSW agreed to reassess the matter and brought the duty payable from \$68,000 down to \$50 (plus some interest).

Revenue NSW became aware there was additional documentation which would have resulted in a more favourable outcome for the taxpayer, and it has now identified ways it can better assist other taxpayers in this process. The agency contacted the complainant directly to assist with obtaining additional information and documentation to allow Revenue NSW to conduct a reassessment in the transaction attracting a nominal rate of duty.

### What can we learn?

This case shows that in some circumstances, like when further information becomes available, an agency can reconsider its decision. Agencies can commit to continuous improvement by handling complaints about their administrative processes, and our office can assist members of the public to seek a resolution to their individual concerns.

# Hardship support to retrieve an impounded dog

## Public authority: a local Council

### Complaint overview

A complainant called us to complain about their dog being impounded by Council after it escaped the yard. The complainant was a young person who was the sole carer for their grandparent, and they did not have the capacity or support to manage the dog in accordance with legal requirements for microchipping and lifetime registration. The complainant had a strong bond with their dog and was distressed by the possibility that the dog would be euthanised by Council if it could not be retrieved from Council's facility.

The complainant contacted us because they could not obtain a payment plan from Council to pay the dog's registration and boarding fees before it would be released. Under the *Companion Animals Act 1998* the dog must be registered before it can leave council facilities.

### What was the outcome?

We approached Council to see if we could assist with a mutually acceptable pathway to resolve the complaint. Council required payment of \$550 but the complainant was only able to raise \$50. On reviewing the complainant's circumstances, Council decided to:

- Waive the costs of microchipping, providing it free of charge.
- Facilitate lifetime registration of the dog – although the fee for this could not be waived and the dog would be held until the complainant could pay the fee.
- Start a payment plan for the dog's boarding fees, to be progressively paid by the complainant.
- Work with the complainant to ensure understanding that their other dog would be properly microchipped and registered.

The complainant continued to raise funds, including by collecting and returning cans and bottles for recycling. As the dog was held during a holiday period, Council would have had to decide whether it should be put down if it could not be rehomed. Fortunately, the dog was returned to the complainant before this occurred.

### What can we learn?

This complaint shows that the resolution of a matter can look different based on the needs and circumstances of the complainant. Resolving the matter with flexibility in this way also restored the complainant's faith in Council, while Council had the opportunity to educate a dog's owner on their legal responsibilities.

# Conciliation leads to improved service delivery

## Public authority: Department of Communities and Justice

### Complaint overview

A complainant told us the Department of Communities and Justice (**DCJ**) had contacted her after it received information about her being assaulted by her ex-partner. Her son was less than 6 months old. The complainant and her son had moved out of the accommodation she was sharing with her ex-partner and had moved into her parents' house. A representative of DCJ wanted to visit her home to check on the welfare of her son. The DCJ caseworker visited her at her parents' home and told her that she was satisfied that the complainant's son was safe. After the visit, DCJ contacted the complainant again to ask for further information. The woman felt that DCJ's inquiries were unnecessary and intrusive.

We conciliated the complaint.

### What was the outcome?

The complainant and DCJ were able to reach an agreement through conciliation.

DCJ agreed to meet with the complainant after the conciliation to discuss the types of support it could provide to her and her son. It also agreed to convey her experience and the impact on her to the leadership and casework teams in DCJ. The complainant agreed to share her experience with DCJ staff so they could learn about the impact of their actions on her.

DCJ apologised to the complainant, acknowledging that there had been practice and communication gaps and that it had not explained what its processes are when conducting a safety assessment and why it requests certain information.

### What can we learn?

This is an example of how agencies can learn from a complainant's experience through conciliation and use that insight to improve their service delivery.

# Improving communication with carers

## Public authority: Community services provider

### Complaint overview

An authorised carer contacted us telling us that she cared for a young person, and that the young person's sister regularly attended their home for family contact sleepovers. The sister, who was also in out-of-home care, had self-placed at her grandmother's home, and did not want to return to her residential placement. The authorised carer was concerned that this was not safe.

The authorised carer reported her concerns to the service provider and offered to care for the sister long term. The authorised carer told us that the service provider had told her the sister must return to her residential placement. The sister was distressed and wanted to stay with the authorised carer. The sister returned to the residential placement, which broke down, and was then placed with several different carers. The service provider asked the authorised carer if the sister could stay with her for respite. The authorised carer agreed to this, and reported she did not receive a carer's allowance or reimbursement for other expenses, including a school camp.

We conciliated the complaint.

### What was the outcome?

The woman and representatives of DCJ were able to reach an agreement through conciliation.

The service provider agreed to pay a fee-for-service for the care of the sister and reimburse previous and future expenses. It also agreed to meet with the sister to ascertain her views about where she would be placed in future and undertook to contact the authorised carer afterwards to advise them of the sister's views and the next steps.

The service provider undertook to address the issues discussed at the conciliation, with a view to improving communication with carers and being clear about roles and responsibilities.

### What can we learn?

This case provides an example of how service providers can hear about the experience of foster carers through conciliation. In this case, the service provider was able to discuss additional support that the carer needed to support the sister.

# Conciliation leads to improved support

## Public authority: Department of Communities and Justice

### Complaint overview

An Aboriginal person contacted us to raise concerns about the care of her teenage brother, who was in out-of-home care.

The brother had just started high school, and his placement had broken down. He was moved from one town in regional NSW to another town in regional NSW, 3 hours' drive away where he stayed in a residential placement with other children. He engaged in risky behaviours there, including drinking and smoking. He attempted to return to his original town by train multiple times, and he would regularly ring his sister asking to come home. The unexpected loss of their father was traumatic for both siblings. The brother caught a train back to his original regional town and refused to return to his placement. The brother lived with her, but she did not receive any support from DCJ.

The sister advised DCJ that her brother needed significant support, including enrolment at school, counselling and medication for ADHD. The high school where the brother previously attended refused to enrol him due to his previous behaviour. His other siblings attended the school.

We conciliated the complaint.

### What was the outcome?

The sister was able to reach an agreement with DCJ. DCJ apologised for her experience, and in particular for the delay in obtaining support. It undertook to arrange several supports as soon as practicable, including a weekly delivery of groceries, liaison with the Department of Education's out of home care liaison officer, support for the brother to engage with an Aboriginal cultural and mentoring service, repair of the brother's mobile phone and purchase of a SIM card. It also agreed to cover various expenses, including to allow the brother to participate in a sporting competition and mental health support.

DCJ agreed to undertake a home visit at the sister's home to discuss further supports needed for her brother, and a DCJ representative gave her their direct telephone and email contact details.

DCJ also undertook to send a weekly email to the sister to update her on her brother's placement and other supports. It arranged a home visit schedule, with a caseworker visiting both siblings on a regular basis.

### What can we learn?

The conciliation resulted in the implementation of a range of supports for a vulnerable Aboriginal child and support for his adult sibling, who was advocating for his interests. This case provides an example of how service providers can work in an interagency collaborative manner to resolve complaints for people with complex support needs.

# Conciliation leads to accessing appropriate support

## Public authority: Community services provider/Department of Communities and Justice

### Complaint overview

A 21-year-old Aboriginal young person contacted us, telling us that he used to be in out-of-home care. He said he had been trying to get help, but no one would help him. He was homeless and not employed or enrolled in education.

We conciliated the complaint.

### What was the outcome?

The young person (supported in the conciliation by advocates from Legal Aid), representatives of the service provider and representatives of DCJ were able to reach an agreement.

DCJ apologised for the young person's experiences in out-of-home care and the impact it had had on his life. It arranged for an urgent food voucher and undertook to check its records to determine whether he was entitled to independent living allowance backpay.

The community services provider agreed to arrange intensive case management for him for a period of 4 months, with the casework undertaken by a caseworker the young person knew. It also undertook to agree a specific casework plan with him and to liaise with DCJ about his aftercare financial support plan.

Possible issues to be addressed in the casework plan included a functional assessment, referral to the NDIS for supports, support with housing, mental health assessment and support, income support and assistance with obtaining identification documents.

### What can we learn?

The conciliation resulted in the implementation of a range of supports for a vulnerable Aboriginal person who may have otherwise not have received the supports he was entitled to receive. This case provides an example of the importance of service providers making their processes more accessible and transparent for young people.

# Case management approach to guardianship

## Public authority: Community services provider

### Complaint overview

A foster carer contacted us and said she and her husband had 5 children in their care, 3 of whom are Aboriginal. The carer's husband is also Aboriginal. She was concerned that the case management agency was not assisting her and her husband to obtain guardianship of the children.

She told us that the case management agency had not provided clear information or guidance around guardianship. The foster carer told us that the children had regular family time with their mothers and other family members. The carer also raised concern about how respite care was provided to the children. Despite her concerns, the foster carer confirmed with our office that she wished to continue to work with the case management agency and did not wish to transfer to a different one.

We conciliated the complaint.

### What was the outcome?

The carer, representatives of the case management agency and representatives were able to reach agreement through conciliation.

The case management agency provided reasons for their decision regarding the delay in initiating guardianship. It also funded advocacy and support services for the foster carer to assist her in meetings and agreed to arrange a meeting with the Aboriginal Medical Service to consult about cultural planning for the Aboriginal children.

The parties agreed to convene a family group conference with an Aboriginal facilitator to discuss guardianship, cultural issues and family time with the Aboriginal children's family members. The case management agency and DCJ also agreed to conduct a permanency consultation.

### What can we learn?

The conciliation resulted in the implementation of a range of supports for a vulnerable Aboriginal person who may have otherwise not have received the supports he was entitled to receive. This case provides an example of the importance of service providers keeping carers and children linked with appropriate support services while complex legal matters, such as guardianship, are in train.

# Fraudulent number plates

## Public authority: Service NSW

### Complaint overview

A complainant told us that Service NSW had not realised that his privately purchased number plates were fraudulent and had allowed him to place the number plates onto his registered vehicle. The complainant was pulled over by police, who were concerned about the appearance of the number plates and told him he needed to seek new number plates as soon as possible to continue driving. The complainant sought new number plates at his own expense and paid for the fraudulent plates to be remade according to the required specifications. He complained to Service NSW without a resolution.

We made preliminary inquiries with Service NSW to determine whether there had been an opportunity to identify the fraudulent number plates, and to find out more about how it handled his complaint.

### What was the outcome?

In its response to our preliminary inquiries, Service NSW identified that there was a missed opportunity to identify the unusual appearance of the number plates. Following formal suggestions to the agency, the complainant was offered a refund for the new number plate and storage expenses. He also received a formal apology from Service NSW.

Service NSW has escalated this issue for internal discussion and provision of guidance on how to appropriately escalate a possible fraudulent set of number plates.

The complainant was happy with the outcome and was refunded the money he had paid to the agency following the error.

### What can we learn?

While we could not fix the issue with the purchase of fraudulent number plates from a private seller, this case highlights the importance of agencies remaining aware of issues in the private sector that could affect their services.

Service NSW recognised the staff member's error in not identifying that the number plates appeared unusual and were likely fraudulent. Once the key issues are raised with an agency, they can explain how the error occurred, consider the implementation of strategies to reduce recurrence and provide the complainant with a fair outcome.

# A seatbelt offence

## Public authority: Revenue NSW

### Complaint overview

A complainant told us he had been fined for a passenger incorrectly wearing their seatbelt. The fine was the result of a camera-detected offence. The complainant had sought an internal review by Revenue NSW on 2 occasions, and each time he was told that the fine would remain. The complainant disagreed, and was adamant the passenger had been properly wearing the seatbelt correctly. He claimed that the photograph was misleading because the belt was partially covered by the passenger's arms being crossed. The complainant and his passenger recreated the photographs in the vehicle while wearing the same clothes to demonstrate that the passenger was likely wearing their seatbelt correctly.

We undertook preliminary inquiries with Revenue NSW to better understand how they interpreted the images, and how they carried out the 2 internal reviews.

### What was the outcome?

Revenue NSW responded to our inquiries, describing how they undertook the 2 reviews. After our preliminary inquiries it decided that in this circumstance the fine should be waived, agreeing that it should not have been issued in the first place.

### What can we learn?

This case highlights how complainants can be a valuable source of information on how government agencies exercise their functions. One of the key concerns for the complainant was that he felt he had exhausted the internal avenues for an appropriate resolution to their complaint. When required to explain the fairness of their decision, the agency showed a willingness to change their decision and provide internal feedback to improve future administration. The case also highlights the risk of potential over-reliance on technology, even where decisions may be subject to human review.

# Debt and hardship provisions

## Public authority: Service NSW

### Complaint overview

A complainant told us that they were being pursued for repayment of a grant. He said he was experiencing financial difficulties and was unable to repay the debt. He had sought a review with Service NSW but it had been declined, and his tourism-focused business remained financially unstable following setbacks during COVID-19 lockdowns.

We referred the complaint directly to Service NSW to consider whether the situation met their hardship policy.

### What was the outcome?

Service NSW offered the complainant another opportunity to submit further tax and financial information to provide evidence of his difficult financial circumstances. Following a further review by the agency, the debt was waived on the basis of financial hardship. The agency had implemented a hardship review policy, noting the impact of a repayment on an individual's financial circumstances.

### What can we learn?

. This case shows that the circumstances of an individual can be an important factor in an agency's decision making, and highlights the importance of agencies having careful regard to hardship considerations in accordance with their policies. It also highlights how our office can assist with highlighting the impact of a decision on a person's livelihood.

# Complaints about searches of inmates following suspected internal secretion of contraband

## Public authorities: Corrective Services NSW and NSW Health

### Complaint overview

Over a period of time, we received 6 complaints from people in custody who had been suspected of internally secreting contraband whilst in custody, and who raised concerns about how they were treated as a result.

Four incarcerated women and one man told us they had been taken to hospital after a body scan conducted by custodial staff had indicated the possible presence of an internally secreted item. These individuals told us that they had not secreted items but had been taken to hospital and subjected to internal searches. None of the individuals were found to have contraband secreted on or in their bodies.

These individuals were housed at different correctional centres and taken to different hospitals.

We sought and received a range of information from Corrective Services NSW (**CSNSW**), the Justice Health & Forensic Mental Health Network (**Justice Health NSW**) and local health districts.

### What was the outcome?

We received a range of information from CSNSW, Justice Health NSW and local health districts. Overall, it appeared that there had been insufficient guidance provided to custodial and health staff about how to handle incidents where incarcerated people are suspected of internally secreting items. As a result, there are at times significant inconsistencies in the way inmates in similar circumstances are treated. Further, at times incarcerated people appear to be subjected to dehumanising and (re)traumatising treatment, including medical treatment where meaningful consent may not have been sought or provided.

As a result, we suggested under s 31AC of the Ombudsman Act that CSNSW and NSW Health work together to develop clear policies, processes and guidance for staff on how inmates are to be managed when suspected of having internally concealed (ingested or inserted) a prohibited item.

Both agencies supported our suggestions and have been working to implement the suggested actions.

### What can we learn?

This case highlights how systemic issues can be identified through discrete complaints, and why it can be helpful for agencies to monitor complaints and analyse complaint data for repeat issues, patterns and trends across their operations.

# Compensation order repayments

## Public authority: Corrective Services NSW

### Complaint overview

A man in custody complained to us that he had recently been issued with a compensation order of \$207 after he was found guilty of the correctional centre offence of damaging property. He felt that this was unfair because all the money in his gaol trust account (at that stage \$142) was withdrawn leaving him with no money to spend on other items like buy-ups (for example groceries and toiletries) or telephone calls.

The man told us that he had raised concerns with custodial staff but was told a local policy enabled staff to deduct all funds from an inmate's account when a compensation order was issued.

We made inquiries with the centre governor to better understand what had happened and the reasons for decisions made.

### What was the outcome?

The centre governor confirmed that a local operating procedure permitted all funds to be deducted from an inmate's account for compensation owing, as occurred in this instance.

We were aware that this local procedure conflicted with the Corrective Services NSW policy. The policy stated that what should have occurred was an automatic weekly deduction at 25% of an inmate's wages and 75% of all other payments the inmate receives.<sup>5</sup> The policy provides the governor with discretion to make other deduction arrangements, such as where the inmate had sufficient funds to pay the compensation amount in full, however none of those circumstances were relevant in this matter. We contacted the governor again to discuss this apparent conflict, and to understand why it may have occurred. We were advised that the local practice permitting all monies to be deducted from an inmate's account had been based on guidance in an informal and outdated training manual.

We were told that the training manual would be converted to a local operating procedure and steps would be taken to ensure its provisions, and future decisions, are consistent with broader policies. We were also advised that the \$142 initially taken out of the man's account had been refunded to him, and that deductions would be taken from his account at the default rate.

### What can we learn?

Over time an agency's policies, procedures and local practices can diverge unintentionally. This case shows how complaints can help identify where such issues arise, and prompt agencies to review relevant materials for clarity and consistency.

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<sup>5</sup> However deductions must not be withdrawn from an inmate's Centrelink payments.

# Correcting details on a driver licence

## Public authority: Service NSW

### Complaint overview

A complainant told us about an ongoing issue with their name being recorded incorrectly on their driver's licence, where their first and last names were printed in incorrect order. They were told they would need to apply for a change of name at a cost of \$220 to rectify the issue.

We made preliminary inquiries with Service NSW, which included querying how the error had occurred.

### What was the outcome?

Service NSW advised that the complainant could attend their nearest Service NSW centre with their identification documents to have their licence corrected. It was agreed that the documents supplied by the person were sufficient to correct the name format, and a change of name certificate was not required.

We assisted by facilitating an appointment between Service NSW and the complainant, and their name was successfully corrected without incurring an additional cost of a change of name certificate.

### What can we learn?

This case shows how we can help complainants receive a timely response to their concerns and to bring an issue to the attention of the relevant agency. Service NSW contacted us immediately upon receipt of the preliminary inquiries and promptly resolved the issue.

# A speeding fine is waived

## Public authority: Revenue NSW

### Complaint overview

A complainant told us that, in November 2024, they received a speeding fine in the mail from Revenue NSW, including overdue fees, for an offence that allegedly occurred in 2018. The complainant objected to the fine and advised Revenue NSW that it could not have been them driving the vehicle as they did not live in or drive in New South Wales, had lived in Queensland since 2013 and had surrendered their NSW driver's licence back in 2013 when they moved interstate.

Revenue NSW declined the complainant's objection to the fine on the grounds that the driver of the vehicle, who was issued the fine, had produced a NSW driver licence.

### What was the outcome?

We were able to resolve the complaint after requesting information from Revenue NSW. They agreed to waive the fine and any overdue fees because the fine was sent to the incorrect address, and they agreed that the complainant had surrendered their licence in 2013.

### What can we learn?

This case provides a good example of a government agency being open to reviewing the information available to it and correct a mistake. Asking questions of government agencies is an effective way of understanding their processes, and how mistakes can be made in their review processes.

# Lengthy delay in processing a death certificate

## Public authority: NSW Registry of Births Deaths & Marriages

### Complaint overview

A customer complained about a lengthy delay in processing a death certificate application. The delay meant that the certificate was no longer of use to her, so she emailed the NSW Registry of Births Deaths & Marriages (**the Registry**) to withdraw her application and to request a refund of the application fee. Almost 3 weeks later, she received an email from the Registry notifying her that her certificate had been printed and would be posted to her. The customer replied promptly, asking again for a refund. The Registry had informed her that as the service she requested had been performed, a refund could not be issued.

We wrote to the Registry seeking further detail about its decision to decline the refund request and asking whether it would consider refunding the application fee.

### What was the outcome?

The Registry responded to our inquiries, apologised to the customer and provided her with a full refund.

We also wrote to it under s31AC of the *Ombudsman Act* expressing concern that its refund policy wording may limit the full exercise of the registrar's broad discretion to consider requests for fee refunds. We suggested it revise its policy and train its staff in the exercise of broad discretionary powers.

We also suggested that it:

- provide information to customers about the process for seeking a review of a decision not to refund a fee
- adjust its practices so that if a request is made to cancel and refund an application before a certificate is printed, the request is considered prior to printing
- consider amending its refunds policy to include significant delay or error by the registry as a factor to be considered in the exercise of the discretion to refund fees.

The registrar agreed with all our suggestions and told us they would be implemented throughout the Registry. A revised refunds policy was published on the registry website in May 2025.

During our inquiries into this complaint, we also liaised with the registry about several other systemic issues we had identified in a scan of our complaint holdings. This liaison resulted in:

- improved policies, for example relating to the use of discretion to remit fees, and providing reasons if refunds are declined
- better information about registry processes for home births (particularly those without medical involvement) to be included in a new births policy
- website changes to improve access to clearer registration and fee waiver information.

### What can we learn?

This case highlights the importance of ensuring that policies that guide staff in the exercise of broad statutory discretions are carefully worded to ensure delegates are free to consider all relevant circumstances. It also demonstrates the benefits of a collaborative approach to achieving better outcomes for customers.

The Registry's positive engagement with our office on other systemic issues also shows how significant policy and operational improvements can be achieved through effective liaison.

# Appendix:

## The 6 principles for effective complaint management



# The 6 principles for effective complaint management

## Treat complainants with respect

### Your organisation will:

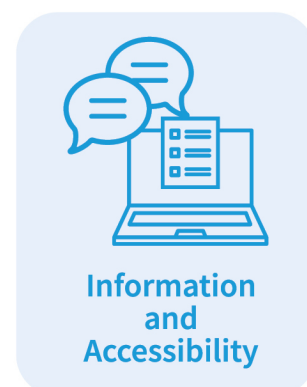
- treat complainants with courtesy and respect
- require staff to treat complainants with courtesy and respect in your complaint policy
- be responsive
- train your public contact staff in customer service, complaint handling and management of complex complaints and complaints from people in distress, who require additional support or have diverse needs
- take appropriate action when your organisation receives complaints about its staff
- review the type and number of complaints your organisation receives about its staff
- ensure that people can complain without fear of detrimental action.



## Make it easy for people to complain

### Your organisation will:

- make it easy for customers to complain and help them to lodge their complaints
- provide easy-to-access information about the complaints process in different formats and mediums
- tell customers about:
  - how to complain, for example online, email, in person, in writing
  - what information you need from customers to assess their complaints
  - what to expect from the complaints process
  - who to contact for more information
  - how complaints have helped improve your organisation's service.



## Keep complainants informed

### Your organisation will:

- keep complainants informed about the status of their complaint
- acknowledge that you've received their complaint and tell the complainant:
  - who to contact for more information about their complaint
  - what the next steps will be in the complaint process
  - how long your organisation will likely need to finalise the complaint.
- use the most appropriate channel to communicate with the complainant and:
  - update them about their complaint's progress regularly (as specified in your procedure)
  - tell them the outcome of their complaint and explain the reason for it (for example, tell them what action was taken and how reached your decision)
  - explain and apologise when things go wrong.



## Give complainants a contact person

### Your organisation will:

- make sure that staff who manage complaints are suitably trained and skilled
- allocate a complaint to one person (or one team) and give complainants their contact details
- generally, have frontline staff resolve a complaint themselves and escalate serious or complex complaints to a more appropriate officer or team.



## Deal with complaints as soon as possible

### Your organisation will:

- do your best to deal with complaints as quickly as possible
- set and make public expected timeframes for finalising complaints
- set these timeframes to reflect the different levels of seriousness, urgency and complexity across the complaints you receive
- contact the complainant and explain why, if there are unavoidable delays when dealing with a complaint.



## Tell complainants what you do with their information

### Your organisation will:

- let complainants know that you record and analyse information from your complaint management process. Explain that this includes the:
  - number of complaints received
  - number of complaints finalised
  - percentage of complaints finalised within your KPIs
  - issues raised by complaints
  - actions taken in response to complaints
  - systemic issues identified
  - number of requests received for internal or external review.



# Pursuing fairness for the people of NSW.

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